

INSTRUCTIONS

1 **1**

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1667

CERTIFICATE OF DEATH

01631

Reg. Dist. No. 182

| | | | | | | | |
|---|------------------|---|----------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Harford</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Harford</u> | |
| CITY (If outside corporate limits, write RURAL OR end, give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | TOWN | |
| <u>X</u> TOWN <u>Rural-- Bel Air</u> | | <u>4 mos.</u> | | TOWN <u>Maulsby St., Bel Air, Md.</u> | | <u>X</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| <u>90</u> <u>Harford Convalescent Home</u> | | | | <u>1</u> | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>Joseph Henry Ayres</u> | | | | <u>February 24, 1955</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| <u>Male</u> | <u>W</u> | <u>Wid.</u> | <u>Feb. 26, 1880</u> | <u>74</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>U.S. mail delivery</u> | | <u>Station to Post Office</u> | | <u>Harford County, Maryland</u> | | <u>U.S.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>John Ayres</u> | | | | <u>Ann R. Robinson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>No</u> | | <u>218-18-7926</u> | | <u>Mrs. Elizabeth A. Caplan</u> | | <u>Elkton, Md.</u> | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| IMMEDIATE CAUSE (A) <u>CEREBRAL THROMBOSIS, terminating</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Ch. Cardio-vascular disease</u> | | | | | | <u>3 da</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | <u>?</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> el work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Sept. 1953</u> to <u>Feb. 24, 1955</u> , that I last saw the deceased alive on <u>Feb. 23, 1955</u> , and that death occurred at <u>6:30 a.m.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | DATE SIGNED | | | |
| <u>Willard P. Hudson</u> M.D. Forest Hill Md. | | | | <u>2-24-55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>Feb. 26, 1955</u> | | <u>Bel Air Memorial Gardens</u> | | <u>Bel Air, Harford County, Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| DATE <u>2.25.55</u> | | <u>Priscilla Lowwood</u> | | <u>Robert W. Taylor</u> | | <u>Bel Air, Md.</u> | |

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. RACE

5. DATE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. PLACE OF BIRTH

9. DATE OF BIRTH

10. SEX

11. RACE

12. PLACE OF DEATH

13. TIME OF DEATH

14. CAUSE OF DEATH

15. PLACE OF BIRTH

16. SEX

17. RACE

18. DATE OF BIRTH

19. SEX

20. RACE

21. PLACE OF DEATH

22. TIME OF DEATH

23. CAUSE OF DEATH

24. PLACE OF BIRTH

25. SEX

26. RACE

27. DATE OF BIRTH

28. SEX

29. RACE

30. PLACE OF DEATH

31. TIME OF DEATH

32. CAUSE OF DEATH

33. PLACE OF BIRTH

34. SEX

35. RACE

36. DATE OF BIRTH

37. SEX

38. RACE

39. PLACE OF DEATH

40. TIME OF DEATH

41. CAUSE OF DEATH

42. PLACE OF BIRTH

43. SEX

44. RACE

45. DATE OF BIRTH

46. SEX

47. RACE

48. PLACE OF DEATH

49. TIME OF DEATH

50. CAUSE OF DEATH

51. PLACE OF BIRTH

52. SEX

53. RACE

54. DATE OF BIRTH

55. SEX

56. RACE

57. PLACE OF DEATH

58. TIME OF DEATH

59. CAUSE OF DEATH

60. PLACE OF BIRTH

61. SEX

62. RACE

63. DATE OF BIRTH

64. SEX

65. RACE

66. PLACE OF DEATH

67. TIME OF DEATH

68. CAUSE OF DEATH

69. PLACE OF BIRTH

70. SEX

71. RACE

72. DATE OF BIRTH

73. SEX

74. RACE

75. PLACE OF DEATH

76. TIME OF DEATH

77. CAUSE OF DEATH

78. PLACE OF BIRTH

79. SEX

80. RACE

81. DATE OF BIRTH

82. SEX

83. RACE

84. PLACE OF DEATH

85. TIME OF DEATH

86. CAUSE OF DEATH

87. PLACE OF BIRTH

88. SEX

89. RACE

90. DATE OF BIRTH

91. SEX

92. RACE

93. PLACE OF DEATH

94. TIME OF DEATH

95. CAUSE OF DEATH

96. PLACE OF BIRTH

97. SEX

98. RACE

99. DATE OF BIRTH

100. SEX

101. RACE

102. PLACE OF DEATH

103. TIME OF DEATH

104. CAUSE OF DEATH

105. PLACE OF BIRTH

106. SEX

107. RACE

108. DATE OF BIRTH

109. SEX

110. RACE

111. PLACE OF DEATH

112. TIME OF DEATH

113. CAUSE OF DEATH

114. PLACE OF BIRTH

115. SEX

116. RACE

117. DATE OF BIRTH

118. SEX

119. RACE

120. PLACE OF DEATH

121. TIME OF DEATH

122. CAUSE OF DEATH

123. PLACE OF BIRTH

124. SEX

125. RACE

126. DATE OF BIRTH

127. SEX

128. RACE

BUREAU V. M.

1955

RECEIVED

FEB 25 1955

RECEIVED

FEB 25 1955

FEB 25 1955

NOTIFICATION

NOTIFICATION TO NEAREST OF KIN OF DEATH OF DECEASED

1668

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01632

CERTIFICATE OF DEATH

Reg. Dist. No. 180

| | | | |
|--|-------------------------------|---|---|
| 1. PLACE OF DEATH COUNTY Harford MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Harford | |
| CITY (If outside corporate limits, write RURAL and give nearest town) Edgewood | | CITY (If outside corporate limits, write RURAL and give nearest town) Edgewood | |
| TOWN Edgewood | | TOWN Edgewood | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural, give location) | |
| 3. NAME OF DECEASED (Type or Print) BLANCHE (First) ELIZABETH (Middle) BAIR (Last) | | 4. DATE OF DEATH (Month) Feb. (Day) 6 (Year) 1955 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married | 8. DATE OF BIRTH Feb. 24, 1896 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY none | 9. AGE last birthday 58 yrs. If under 1 year Months Days If under 24 hrs. Hours Min. |
| 11. BIRTHPLACE (State or foreign country) Cecil Co., Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME John Harris | | 14. MOTHER'S MAIDEN NAME Phoebe Riale | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY No. none | |
| 17. INFORMANT Aldie L. Bair, Edgewood, Maryland. | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

356.1
Immediate cause(a) **HYPOSTATIC PNEUMONIA**

INTERVAL BETWEEN ONSET AND DEATH

14 MONTHS

Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last(b) **AMYOTROPHIC LATERAL SCLEROSIS**

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

NONE

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

NONE

20. AUTOPSY?

Yes ☐ No ☒ (STATE)

| | | | |
|---|--|--------------------------------|-------------------|
| 21. ACCIDENT (Specify) — | PLACE (Home, farm, factory, street, OF office bldg., etc.) — | (CITY OR TOWN) — | (COUNTY) — |
| HOMICIDE | INJURY | | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY — | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/> | HOW DID INJURY OCCUR? — | |

22. I hereby certify that I attended the deceased from **1 NOV**, 1953, to **6 FEB**, 1955, that I last saw the deceasedalive on **4 FEB**, 1955, and that death occurred at **2:45 A.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

| | | | | |
|---|---|---|---|---------|
| 23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF Feb. 8, 1955 | NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens | LOCATION (City, town, or county) Bel Air, Harford, Md. | (State) |
| DATE REC'D BY LOCAL REG. Feb. 7, 1955 | REGISTRAR'S SIGNATURE Norma S. Moore | 24. FUNERAL DIRECTOR Howard K. Mc Comas & Son, Abingdon, Md. | | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 9 1955
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1669

01633

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 181

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Harford</u> | | MARYLAND | | STATE <u>MD</u> | | COUNTY <u>Harford</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Aberdeen</u> | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Aberdeen Rural #2</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rural #2 Kahubacher's Store</u> | | | | STREET ADDRESS (If rural, give location) <u>Kahubacher's Store</u> | | | |
| 3. NAME OF DECEASED: (Type or Print) <u>Ronald Edward Barton</u> | | | | 4. DATE OF DEATH <u>February 10</u> 19 <u>55</u> | | | |
| 5. SEX: <u>Male</u> | | 6. COLOR OR RACE: <u>White</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u> | | 8. DATE OF BIRTH: <u>Dec 21-1954</u> | |
| 9. AGE last birthday: <u>1</u> yrs. <u>1</u> month <u>18</u> days | | 10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Infant</u> | | 11. BIRTHPLACE (State or foreign country): <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | |
| 13. FATHER'S NAME: <u>Clarence Barton</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Norma Lee Hughes</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY No.: _____ | | 17. INFORMANT & ADDRESS: <u>Aberdeen Police Dept Aberdeen MD</u> | | | |

| | | | | | |
|---|--|--|--|--|--|
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>490X</u> Immediate cause (a) <u>Lobar pneumonia</u> DUE TO Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) _____ | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | |
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDING OF OPERATION: | | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH: | | 21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | | 21c. (City or town) (County) (State) | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | |
| SIGNATURE <u>Dorold E Palmer</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>2/10/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> | | | |
| 23. BURIAL, CREMATION, REMOVAL: <u>Removal</u> | | DATE THEREOF <u>2/11/55</u> | | NAME OF CEMETERY OR CREMATORY <u>Seltzer family cemetery</u> | |
| LOCATION (City, town, or county) (State) <u>near Seltzer West Virginia</u> | | DATE REC'D BY LOCAL REG. <u>Feb 11-1955</u> | | REGISTRAR'S SIGNATURE <u>Mellie G. Terry</u> | |
| 24. FUNERAL DIRECTOR <u>John G. Darnley</u> | | ADDRESS <u>Aberdeen MD</u> | | | |

10V4172404

RECEIVED

FEB 14 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01634

1670

CERTIFICATE OF DEATH

Reg. Dist. No. 181

| | | | | | | | |
|--|--------------------------------|--|---------------------------------------|---|-----------------------------|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Harford</u> | | MARYLAND | | STATE <u>Miss.</u> | | COUNTY <u>Newton</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hickory</u> <u>61X-3</u> | | | |
| TOWN <u>Aberdeen</u> | | <u>Three hours</u> | | STREET ADDRESS (If rural give location) <u>P.O. Box 62</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u> <u>50 Aberdeen Proving Ground</u> | | | | | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | 4. DATE (Month) (Day) (Year) OF DEATH: | | | | | |
| (Type or Print) <u>Robert Lee Poose</u> | | <u>Feb 6 19 55</u> | | | | | |
| 5. SEX: <u>Male</u> | 6. COLOR OR RACE: <u>Negro</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u> | 8. DATE OF BIRTH: <u>12 July 1930</u> | 9. AGE last birthday <u>24</u> yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Soldier</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>U. S. Army</u> | | 11. BIRTHPLACE (State or foreign country): <u>Mississippi</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>Henry Clay Poose (Deceased)</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Velma Hill</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>1951-pres</u> | | 16. SOCIAL SECURITY NO. <u>425-54-3377</u> | | 17. INFORMANT & ADDRESS: <u>Personnel Service, U. S. Army</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE <u>825X</u> (A) <u>Cerebral Contusion</u> | | | | | | <u>Four hours</u> | |
| ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | | | | |
| (B) DUE TO | | | | | | | |
| (C) DUE TO | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: <u>Feb 6 1955 1055 AM</u> | | 19B. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/> | | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) <u>Highway - Route 40</u> | | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Joppa Harford Md</u> | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Feb 6 1955 1055 AM</u> | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <u>Automobile Accident</u> | | | |
| 22. I hereby certify that I attended the deceased from <u>6 Feb</u> , 19 <u>55</u> to <u>6 Feb</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6 Feb</u> , 19 <u>55</u> , and that death occurred at <u>3:15 P M</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Robert T. Walker</u> | | DATE SIGNED <u>6 Feb 1955</u> | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u> | | DATE THEREOF <u>Feb. 7-1955</u> | | NAME OF CEMETERY OR CREMATORY <u>Hickory Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Hickory Miss</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>Feb. 7-1955</u> | | REGISTRAR'S SIGNATURE <u>Willie G. Perry</u> | | 24. FUNERAL DIRECTOR <u>John G. Sarring</u> | | ADDRESS <u>Aberdeen</u> | |

DEPARTMENT OF HEALTH

10-1

VALLEY'S
CONGRESS
BOND

BUREAU V. S.

FEB 9 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01635

1650

CERTIFICATE OF DEATH

Reg. Dist. No. 183-

| | | | | | | | |
|---|-------------------------|---|-------------------------|---|------------------------|---|-------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Harford</u> | | MARYLAND | | STATE <u>Maryland</u> COUNTY <u>Harford</u> | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Laurel de Grace</u> | | <u>20 years</u> | | TOWN <u>Laurel de Grace</u> | | <u>24</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| <u>Harford Memorial</u> | | | | <u>622 N. Stokes Street</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| (First) (Middle) (Last) | | | | | | | |
| <u>MINNIE Bell BRASWELL</u> | | | | <u>FEB 21 1955</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| <u>F</u> | <u>W</u> | <u>Widowed</u> | <u>Apr. 18, 1886</u> | <u>68</u> yrs. | Months | Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>House wife</u> | | <u>None</u> | | <u>VIRGINIA</u> | | <u>U.S.A.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Link Edwards</u> | | | | <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | |
| | | | | | | <u>MRS. FLORENCE B. FREEMAN</u> | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| <u>420.0</u> | | | | <u>ABEIRBEEN, MD.</u> | | <u>1 DAY</u> | |
| IMMEDIATE CAUSE (A) | | | | <u>PNEUMONIA</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | <u>CARDIAC DECOMPENSATION</u> | | <u>2 weeks</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | DUE TO | | <u>ARTERIOSCLEROTIC HEART DISEASE</u> | |
| | | | | (C) | | <u>1 year</u> | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. MAJOR FINDINGS OF OPERATION | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.) | | 21e. INJURY OCCURRED While at work Not while at work | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>2/3</u>, 19<u>55</u>, to <u>2/21</u>, 19<u>55</u>, that I last saw the deceased alive on <u>2/21</u>, 19<u>55</u>, and that death occurred at <u>9:55 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | | | DATE, SIGNED | | | |
| <u>Harrell de Grace, Md.</u> | | | | <u>John H. Wadsworth</u> | | <u>2/21/55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) | |
| <u>BURIAL</u> | | <u>FEB. 24 1955</u> | | <u>ANGEL HILL Cem.</u> | | <u>HAVRE DE GRACE, MD</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>Feb 24 - 1955</u> | | <u>L. Lewis m.d.</u> | | <u>R. Madison Mitchell</u> | | <u>HAVRE DE GRACE MD</u> | |

BUREAU V. S.

RECEIVED

BUREAU V. S.

FEB 25 1955

RECEIVED
FEB 25 1955

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1651 MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01636

CERTIFICATE OF DEATH

Reg. Dist. No. 185

| | | | |
|---|----------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH- COUNTY <u>Harford</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Cecil</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Harford</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Perryville</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u> | | STREET ADDRESS <u>(If rural, give location)</u> | |
| 3. NAME OF DECEASED (Type or Print) <u>George W. Brown</u> | | 4. DATE OF DEATH (Month) <u>February</u> (Day) <u>6</u> (Year) <u>1953</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u> | 8. DATE OF BIRTH <u>12-28-1884</u> |
| 9. AGE last birthday <u>70</u> yrs. | | 10. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN, OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>George Brown</u> | | 14. MOTHER'S MAIDEN NAME <u>Martha Isaac</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u> | | 16. SOCIAL SECURITY No. | |
| 17. INFORMANT AND ADDRESS <u>Rose Brown, Perryville, Md</u> | | 18. MEDICAL CERTIFICATION | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| Immediate cause <u>Cerebral Thrombosis</u> | | <u>2 wks</u> | |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | | <u>?</u> | |
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes mellitus</u> | | <u>?</u> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | |
| HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>2/2</u> , 19 <u>53</u> , to <u>2/6</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>2/6</u> , 19 <u>53</u> , and that death occurred at <u>3:40 p.m.</u> , from the causes and on the date stated above. | | | |
| SIGNATURE <u>Fredrick B. Johnson M.D.</u> | | ADDRESS <u>12 N. Charles St. Baltimore, Md</u> | |
| DATE SIGNED <u>2/6/53</u> | | | |
| 23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u> | | DATE THEREOF <u>Feb. 9, 1953</u> | |
| NAME OF CEMETERY OR CREMATORY <u>Angel Hills</u> | | LOCATION (City, town, or county) (State) <u>Harford, Md</u> | |
| DATE REC'D BY LOCAL REG. <u>Feb. 9, 1953</u> | | REGISTER'S SIGNATURE <u>G. L. Lewis M.D.</u> | |
| 24. FUNERAL DIRECTOR <u>Kenn A. Patterson & Son</u> | | ADDRESS <u>Perryville, Md.</u> | |

RECEIVED

BB 14 1955

BUREAU V. S.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1652

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01637

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

| | | | | | | | |
|--|-------------------------|---|-------------------------|---|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>HARFORD Co</u> | | MARYLAND | | STATE <u>MARYLAND</u> COUNTY | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>HAURC-DE GRACE</u> | | <u>LIFE</u> | | TOWN <u>HAURC-DE GRACE</u> | | <u>24</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| <u>71 HARFORD MEM HOSP</u> | | | | <u>115 MARKET ST.</u> | | <u>1</u> | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>DAVID ALLAN Bucchi</u> | | | | <u>FEB-20 1955</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR (Months) (Days) | IF UNDER 24 HRS. (Hours) (Min.) | |
| <u>MALE</u> | <u>WHITE</u> | <u>SINGLE</u> | <u>8/2/1953</u> | <u>1</u> yrs. | <u>6</u> Months <u>18</u> Days | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>none</u> | | <u>none</u> | | <u>Harford Co., Md</u> | | <u>USA.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Alfred Bucchi</u> | | | | <u>Elena E. Barnard</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>no</u> | | <u>none</u> | | <u>Alfred Bucchi, 115 Market St</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| <u>492X</u> IMMEDIATE CAUSE (A) <u>lincol - Pneumonia</u> | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Dehydration - Acidosis</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>Feb 20, 1955</u>, to <u>Feb 20, 1955</u>, that I last saw the deceased alive on <u>Feb 20, 1955</u>, and that death occurred at <u>9:35 PM</u>, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | M.D. | | ADDRESS (Street, city, town, state) | | DATE SIGNED | |
| <u>C. L. Lewis MD</u> | | <u>Harford Co. Md</u> | | <u>115 Market St</u> | | <u>2-20-55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>2/23/55</u> | | <u>Mt. Evin</u> | | <u>Harford Co. Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>Feb 22-55</u> | | <u>C. L. Lewis MD</u> | | <u>Funeral Home of Don</u> | | <u>Harford Co. Md.</u> | |

RECEIVED
FEB 24 1955
BUREAU

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1653

CERTIFICATE OF DEATH

01638

Reg. Dist. No. 182

| | | | | | | | |
|--|-------------------------------------|---|--|--|---|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Harford</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Harford</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>32</u> TOWN <u>Bel Air</u> | | LENGTH OF STAY (in this place) <u>6 yrs.</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>32</u> TOWN <u>Bel Air</u> | | <u>1</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u> | | | | STREET ADDRESS (If rural give location) <u>Mausby STREET</u> | | | |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>MILTON J. BULL, Sr.</u> | | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>February 20 1955</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>Sept. 14, 1885</u> | | 9. AGE last birthday <u>69</u> yrs. | 10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) <u>0</u> <u>0</u> <u>0</u> <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>FRANK Bull</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sophia Elliott</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>UNK</u> | | 16. SOCIAL SECURITY NO. <u>212-16-0549</u> | | 17. INFORMANT & ADDRESS <u>SEWELL Bull, Bel Air, Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) <u>Uremia, terminating</u> | | | | | | <u>3 da.</u> | |
| ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, (B) <u>Hypertensive Cardio-renal disease, chronic</u> | | | | | | <u>?</u> | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>May 30</u> , 19 <u>55</u> , to <u>Feb. 20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Feb. 19</u> , 19 <u>55</u> , and that death occurred at <u>5</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Willard P. Heddon</u> M.D. <u>Forest Hill, Md.</u> | | | | DATE SIGNED <u>2-20-55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>Feb 22 55</u> | | NAME OF CEMETERY OR CREMATORY <u>BEL AIR MEMORIAL GARDENS</u> | | LOCATION (City, town, or county) <u>MD. Bel Air, Harford Co., BEL AIR</u> | |
| 24. REC'D BY REGISTRAR <u>2-21-55</u> | | REGISTRAR'S SIGNATURE <u>Priscilla Lowndes</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Foster FUNERAL HOME, Joseph W. Foster</u> | | ADDRESS | |

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1654

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01639

Reg. Dist. No. 186

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH- COUNTY HARFORD MARYLAND | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MARYLAND COUNTY HARFORD | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN HAURE DE GRACE | | | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HAURE DE GRACE | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS HARFORD MEMORIAL HOSP. | | | | STREET ADDRESS (If rural, give location) 312 LAFAYETTE | | | |
| 3. NAME OF DECEASED (Type or Print) | | (First) BEULAH | | (Middle) | | (Last) COUTER | |
| 5. SEX FEMALE | | 6. COLOR OR RACE White | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED | | 8. DATE OF BIRTH 3-24-1898 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 9. AGE last birthday 35 yrs. | | 4. DATE OF DEATH FEBRUARY 10, 1955 | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME HARRY WATERS | | | | 14. MOTHER'S MAIDEN NAME JARA FLETCHER | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT AND ADDRESS Howard L. Couter, 312 Lafayette St. Harford, Md. | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 174X Immediate cause (a) Carcinoma of uterus | | | | | | | |
| Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) General Carcinomatosis | | | | | | | |
| (c) Cachexia | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | | |
| 19a. DATE OF OPERATION June 1954 | | | | 19b. MAJOR FINDINGS OF OPERATION Carcinoma of uterus | | | |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | | |
| 21. ACCIDENT SUICIDE HOMICIDE | | (Specify) | | PLACE (Home, farm, factory, street, OF office bldg., etc.) | | (CITY OR TOWN) (COUNTY) (STATE) | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | | HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Feb 1, 1955 , to Feb 10, 1955 , that I last saw the deceased alive on Feb 10, 1955 , and that death occurred at 1:36 A.M. , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE Charles J. Hays, M.D. | | | | ADDRESS Harford, Md. | | DATE SIGNED 2/14/55 | |
| 23. BURIAL, CREMATION REMOVAL (Specify) | | DATE THEREOF 2/12/55 | | NAME OF CEMETERY OR CREMATORY Congel Hill | | LOCATION (City, town, or county) (State) Harford, Md. | |
| DATE REC'D BY LOCAL REG. Feb 12-55 | | REGISTRAR'S SIGNATURE A. D. Lewis, M.D. | | 24. FUNERAL DIRECTOR Harold Chase, Md. | | ADDRESS Harford, Md. | |

RECEIVED

FEB 14 1955

BUREAU V. S.

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

Dr. Palmer, Coroner, suggested that I fill in this certificate. Robert Barthel, M.D.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1671

CERTIFICATE OF DEATH

01640

Reg. Dist. No. 182

| | | | | | | | |
|---|-------------------------|---|-------------------------|---|---------------------------------|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>HARFORD</u> | | STATE <u>MD.</u> COUNTY <u>HARFORD</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) | | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| OR TOWN <u>MT. HOREB ROAD</u> | | LENGTH OF STAY (in this place) <u>Life</u> | | OR TOWN <u>MT. HOREB ROAD</u> | | OR TOWN <u>MT. HOREB ROAD</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u> | | STREET ADDRESS <u>STREET R.D. 3 MD.</u> | | STREET ADDRESS | | STREET ADDRESS | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>Augustus Foard Durham</u> | | | | <u>Feb. 19, 19 55</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| <u>M</u> | <u>W</u> | <u>MARRIED</u> | <u>MAR 1, 1888</u> | <u>66</u> yrs. | <u>11</u> Months <u>19</u> Days | <u>19</u> Hours <u>55</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>FARMER</u> | | <u>FARM OWNER</u> | | <u>HARFORD CO. ? MD.</u> | | <u>USA</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>WILLIAM DURHAM</u> | | | | <u>MARTHA VIRGINIA FOARD</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>NO</u> | | <u>218-14-9247</u> | | <u>MRS. ANNA E. DURHAM, STREET, MD.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| IMMEDIATE CAUSE (A) <u>Coronary Thrombosis, acute</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> | |
| ANTECEDENT CAUSE(S) DUE TO <u>Coronary Thrombosis, previous attack.</u> | | | | | | <u>2 years</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>UNDERLYING CAUSE LAST.</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.) | | 21e. INJURY OCCURRED While <input type="checkbox"/> el work <input type="checkbox"/> Not while <input type="checkbox"/> el work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Feb. 19, 19 55</u> to <u>Feb. 19, 19 55</u>, that I last saw the deceased <u>alive on <u>Feb. 19, 19 55</u></u>, and that death occurred at <u>2:30 p.m.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Robert Barthel</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>Forest Hill, Maryland</u> | | DATE SIGNED <u>2-21-55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>BURIAL</u> | | <u>Feb. 22, '55</u> | | <u>Jarrettsville</u> | | <u>Jarrettsville, Md.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>2-21-55</u> | | <u>Bessie L. Foward</u> | | <u>Robert Barthel</u> | | <u>Forest Hill, Maryland</u> | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1951

1. DEPARTMENT OF HEALTH - BALTIMORE 18

2. PLACE OF DEATH

3. NAME OF DECEASED

4. SEX

5. AGE

6. RACE

7. OCCUPATION

8. CAUSE OF DEATH

9. DATE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF BURIAL

16. SIGNATURE OF CREMATION

17. SIGNATURE OF OTHER

18. SIGNATURE OF OTHER

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45. SIGNATURE OF OTHER

BUREAU V. B.

FEB 25 1955

RECEIVED

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1655

01641

Reg. Dist. No. 185

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH: COUNTY <u>Harford</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Harford</u> TOWN <u>Harford</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial D.O.A.</u> | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY (If outside corporate limits write RURAL and give nearest town) <u>Harford</u> OR TOWN <u>Harford</u> STREET ADDRESS (If rural, give location) <u>Adams</u> | | | |
| 3. NAME OF DECEASED: (Type or Print) <u>Isabel</u> (First) <u>Fulton</u> (Middle) <u>Fulton</u> (Last) | | 4. DATE OF DEATH <u>February 19</u> 19 <u>55</u> | | 5. SEX: <u>M.</u> 6. COLOR OR RACE: <u>W.</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> 8. DATE OF BIRTH: <u>4/4/1889</u> 9. AGE last birthday: <u>65</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Acting Captain</u> | | 10b. KIND OF BUSINESS OR INDUSTRY: <u>V.A. Hosp. King B.</u> | | 11. BIRTHPLACE (State or foreign country): <u>Flintville, Md.</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME: <u>G.W. Fulton</u> | | 14. MOTHER'S MAIDEN NAME: <u>Eliza Barrow</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WW. I</u> | | 16. SOCIAL SECURITY No.: <u>214-18-7212</u> | | 17. INFORMANT & ADDRESS: <u>Mrs. Geo. Price, 613 Franklin Harford, Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>422.1</u> Immediate cause <u>Anteriosclerotic C.V. Disease</u> DUE TO Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDING OF OPERATION: | | | | | |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> | | 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | |
| 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | | 21c. (City or town) (County) (State) | | 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | | | |
| 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>Gerald C Palmer</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>2/19/55</u> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u> | | DATE THEREOF: <u>2/22/55</u> | | NAME OF CEMETERY OR CREMATORY: <u>Angel Hill</u> | | | |
| LOCATION (City, town, or county) (State): <u>Harford, Md.</u> | | 24. FUNERAL DIRECTOR: <u>John</u> | | ADDRESS: <u>Harford, Md.</u> | | | |
| DATE REC'D BY LOCAL REG. <u>Feb 22-55</u> | | REGISTRAR'S SIGNATURE: <u>G. L. Lemis m. d.</u> | | | | | |

BUREAU V. S.

FEB 23 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1672

CERTIFICATE OF DEATH

01642

Reg. Dist. No. 182

| | | | | | | | |
|---|----------------------------------|--|---|--|--|---|---|
| 1. PLACE OF DEATH COUNTY <u>HARFORD</u> MARYLAND CITY OR TOWN <u>ROCKS</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>000 Rocks Chrome Hill Rd</u> | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>HARFORD</u> CITY OR TOWN <u>ROCKS</u> STREET ADDRESS <u>Rock Chrome Hill Rd</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>JACKIE RAY GREENE</u> | | | | 4. DATE OF DEATH (Month) <u>FEB</u> (Day) <u>14</u> (Year) <u>1955</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u> | 8. DATE OF BIRTH <u>FEB 14, 1955</u> | 9. AGE last birthday <u>NEW BORN</u> | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HRS. Hours _____ Min. <u>2</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Raymond Columbus Greene</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Nadean Rosella Blackburn</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) | | 17. INFORMANT & ADDRESS <u>Father</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 762.5 IMMEDIATE CAUSE (A) <u>Aspirated amniotic fluid</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Prematurity - aborted at 22 weeks pregnancy.</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>None</u> | | | | 18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH, <u>2 min</u> | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____ | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>14 Feb., 1955</u> , to <u>14 Feb., 1955</u> , that I last saw the deceased alive on <u>14 Feb., 1955</u> , and that death occurred at <u>12:13 AM</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Philip W. Neuman</u> | | | | ADDRESS (Street, city, town, state) <u>307 Hickory, Bel Air, Md</u> | | | |
| DATE SIGNED <u>Feb. 16, 1955</u> | | | | DATE SIGNED <u>14 Feb 55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>Feb. 16, 1955</u> | | NAME OF CEMETERY OR CREMATOR <u>Greenwood Cemetery, Harford Co., Md.</u> | | LOCATION (City, town, or county) (State) <u>Harford Co., Md.</u> | |
| 24. REC'D BY REGISTRAR <u>2-15-55</u> | | REGISTRAR'S SIGNATURE <u>Priscilla Foxwood</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u> | | ADDRESS <u>Harlington Md</u> | |

1025171221

CERTIFICATE OF DEATH

1975

Reg. Cert. No. 185

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BUREAU V. S.

FEB 21 1975

RECEIVED

1656

MARYLAND STATE DEPARTMENT OF HEALTH

01643

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1835

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH: COUNTY <u>Harford</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Harford</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Harford</u> <u>Gloucester</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Belair, Md.</u> X | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hosp</u> | | STREET ADDRESS (If rural, give location) <u>Victory Lane</u> | |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Baby</u> <u>Girl</u> <u>Grogan</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Feb.</u> <u>7</u> <u>1955</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> | 8. DATE OF BIRTH <u>Feb 7 1953</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> |
| 13. FATHER'S NAME <u>Harriet A. Grogan</u> | | 14. MOTHER'S MAIDEN NAME <u>Helena Goodwin</u> | |
| 15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u> | | 16. SOCIAL SECURITY NO. <u>—</u> | 17. INFORMANT AND ADDRESS <u>Helen Grogan</u> |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) ATELECTASIS

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 7, 1955, to Feb 7, 1955, that I last saw the deceasedalive on Feb 7, 1955, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

2025414404

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 14 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1673

CERTIFICATE OF DEATH

Reg. Dist. No.

01644

785

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Harford</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>Harford</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace, Rural</u> | | LENGTH OF STAY (in this place) <u>18 Mos.</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace, Rural</u> | | X | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Havre de Grace Heights</u> | | | | STREET ADDRESS (If rural give location) <u>Havre de Grace Heights</u> | | / | |
| 3. NAME OF DECEASED: (First) <u>Lucy</u> (Middle) <u>Ann</u> (Last) <u>Grover</u> | | | | 4. DATE OF DEATH: (Month) <u>Feb.</u> (Day) <u>23</u> (Year) <u>19 55</u> | | | |
| 5. SEX: <u>Female</u> | | 6. COLOR OR RACE: <u>White</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u> | | 8. DATE OF BIRTH: <u>1-16-1884</u> | |
| 9. AGE last birthday: <u>71</u> yrs. | | 10. USUAL OCCUPATION: Give kind of work done during most of working life, even if retired <u>Domestic</u> | | 11. BIRTHPLACE (State or foreign country): <u>Penna.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME: <u>Henry B. Jones</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Delilah Carlin</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY No.: <u>220-34-5107</u> | | | |
| | | | | 17. INFORMANT & ADDRESS: <u>Havre de Grace, Md. Mrs Carl Wheeler, Havre de Grace, Heights</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | Interval Between Onset And Death | |
| <u>420.1</u> Immediate cause (a) <u>Coronary Occlusion</u> | | | | | | <u>Sudden</u> | |
| Antecedent causes (s) (b) <u>Diseses or conditions, if any, giving rise to the above cause stasting the underlying cause last.</u> | | | | | | | |
| (c) | | | | | | | |
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u> | | | | | | | |
| 19a. DATE OF OPERATION: | | | | 19b. MAJOR FINDINGS OF OPERATION | | | |
| | | | | | | | |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | | PLACE (Home, farm, factory, street, office bldg., etc.) | | (CITY OR TOWN) | | (COUNTY) (STATE) | |
| | | OF INJURY | | | | | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | | INJURY OCCURED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | HOW DID INJURY OCCUR? | | | |
| | | m. | | | | | |
| 22. I hereby certify that I attended the deceased from <u>2/23</u> , 19 <u>55</u> , to <u>2/23</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2/23</u> , 19 <u>55</u> , and that death occurred at <u>home</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Joseph R. Nole</u> | | | | DATE SIGNED <u>2/24/55</u> | | | |
| (Degree or title) <u>Physician</u> | | | | ADDRESS <u>Havre de Grace, Md.</u> | | | |
| 23. BURIAL, CREMATION, REINTERMENT (Specify) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>2-26-1955</u> | | <u>Hopewell</u> | | <u>Port Deposit, Md. Rural</u> | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR'S ADDRESS | | | |
| <u>Feb-24-1955</u> | | <u>A. L. Lewis m. D.</u> | | <u>Lee A. Patterson & Son</u> <u>Perryville, Md.</u> | | | |

BUREAU V. S.

FEB 28 1955

RECEIVED

James Watson

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01645

1657

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

| | | | | | | | |
|--|------------------------------|---|---|---|----------------------------|-------------------------------------|------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Harford</u> | | STATE <u>Md</u> COUNTY <u>Harford</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) | | TOWN <u>31</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | STREET ADDRESS (If rural give location) | | TOWN <u>31</u> | |
| TOWN <u>Harford - death place 15 min.</u> | | HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u> | | STREET ADDRESS <u>422 Lorraine St.</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>Katherine</u> (First) <u>Gula</u> (Middle) <u>Bula</u> (Last) | | | | <u>2-19</u> 19 <u>55</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | 10. IF UNDER 1 YEAR | 11. IF UNDER 24 HRS. | |
| <u>Female</u> | <u>White</u> | <u>Married</u> | <u>July 13-1889</u> | <u>65</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>Home-wife</u> | | <u>Home</u> | | <u>Austria</u> | | <u>USA.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>(Unknown) Partyska</u> | | | | <u>(Unknown)</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>no</u> | | <u>none</u> | | <u>George G. Gula</u> <u>2001</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 332X IMMEDIATE CAUSE (A) <u>CEREBRAL THROMBOSIS</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>GENERALIZED ARTERIOSCLEROSIS</u> | | | | <u>10 YEARS</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) | | (County) (State) | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work Not while at work | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>SEPT. 1, 1952</u>, to <u>FEB. 19, 1955</u>, that I last saw the deceased alive on <u>FEB. 19, 1955</u>, and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | ADDRESS (Street, city, town, state) | | DATE SIGNED | | | |
| <u>Brown McDonald</u> M.D. | | <u>Aberdeen, Md.</u> | | <u>FEB 19, 1955</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | | | |
| <u>Removal</u> | <u>Feb 20-1955</u> | <u>Mt. Olivet Cemetery</u> | | <u>Maspeth Long Island N.Y.</u> | | | |
| 24. REC'D BY REGISTRAR | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | | |
| <u>Feb 21-1955</u> | <u>H. L. Lewis</u> | | <u>John G. Tarring</u> | | <u>Aberdeen, Md.</u> | | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1. NAME OF DECEASED

MARYLAND

2. SEX

MALE

3. AGE

25

4. DATE OF DEATH

FEB 10 1910

5. PLACE OF DEATH

BALTIMORE, MD.

6. CAUSE OF DEATH

SCURVY

7. PLACE OF BIRTH

IRELAND

8. OCCUPATION

LABORER

9. MARITAL STATUS

SINGLE

10. SIGNATURE OF DECEASED

[Signature]

11. SIGNATURE OF WITNESS

[Signature]

12. SIGNATURE OF PHYSICIAN

[Signature]

13. SIGNATURE OF CLERK

[Signature]

14. SIGNATURE OF REGISTRAR

[Signature]

15. SIGNATURE OF JUDGE

[Signature]

16. SIGNATURE OF SHERIFF

[Signature]

17. SIGNATURE OF CORONER

[Signature]

18. SIGNATURE OF JURY

[Signature]

19. SIGNATURE OF JURY

[Signature]

20. SIGNATURE OF JURY

[Signature]

21. SIGNATURE OF JURY

[Signature]

22. SIGNATURE OF JURY

[Signature]

23. SIGNATURE OF JURY

[Signature]

24. SIGNATURE OF JURY

[Signature]

25. SIGNATURE OF JURY

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26. SIGNATURE OF JURY

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27. SIGNATURE OF JURY

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28. SIGNATURE OF JURY

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29. SIGNATURE OF JURY

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30. SIGNATURE OF JURY

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31. SIGNATURE OF JURY

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32. SIGNATURE OF JURY

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33. SIGNATURE OF JURY

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34. SIGNATURE OF JURY

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35. SIGNATURE OF JURY

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36. SIGNATURE OF JURY

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37. SIGNATURE OF JURY

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38. SIGNATURE OF JURY

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39. SIGNATURE OF JURY

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40. SIGNATURE OF JURY

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41. SIGNATURE OF JURY

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42. SIGNATURE OF JURY

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48. SIGNATURE OF JURY

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49. SIGNATURE OF JURY

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50. SIGNATURE OF JURY

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51. SIGNATURE OF JURY

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52. SIGNATURE OF JURY

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53. SIGNATURE OF JURY

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54. SIGNATURE OF JURY

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55. SIGNATURE OF JURY

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56. SIGNATURE OF JURY

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57. SIGNATURE OF JURY

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58. SIGNATURE OF JURY

[Signature]

59. SIGNATURE OF JURY

[Signature]

60. SIGNATURE OF JURY

[Signature]

BUREAU V. S.

FEB

RECEIVED

1

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1658

CERTIFICATE OF DEATH

01646

Reg. Dist. No. 185

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>HARFORD</u> | | MARYLAND | | STATE <u>PENNSYLVANIA</u> COUNTY <u>PHILADELPHIA</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Havre de Grace</u> | | | | TOWN <u>PHILADELPHIA</u> <u>ACE 75X-3</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Mem. Hospital</u> | | | | STREET ADDRESS (If rural give location) <u>314 N. 41ST STREET</u> ✓ | | | |
| 3. NAME OF DECEASED (Type or Print) <u>EDWARD ELIZAH HARRIS</u> | | | | 4. DATE OF DEATH <u>2 22 19 55</u> | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>Negro</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u> | | 8. DATE OF BIRTH <u>1-15-1884</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>LONGSHOREMAN</u> | | 9. AGE last birthday <u>71</u> yrs. | | 11. BIRTHPLACE (State or foreign country) <u>ATLANTA, GA.</u> | |
| 13. FATHER'S NAME <u>NO RECORD</u> | | | | 14. MOTHER'S MAIDEN NAME <u>NO RECORD</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>—</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT & ADDRESS <u>MRS SUSIE LEE-HAVRE-DE-GRAVE</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 420.0 IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u> | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO | | | | | | | |
| 200X (C) <u>Hypertensive Arteriosclerotic Heart disease</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>2/21</u> , 19 <u>55</u> , to <u>2/22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2/22</u> , 19 <u>55</u> , and that death occurred at <u>12:40 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>George J. Stansbury, M.D.</u> | | | | ADDRESS (Street, city, town, state) <u>569 Revolution St, Havre de Grace, Md.</u> DATE SIGNED <u>2/23/55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | DATE THEREOF <u>2-27-55</u> | | NAME OF CEMETERY OR CREMATORY <u>UNION METHODIST CEM.</u> | | LOCATION (City, town, or county) (State) <u>SWANS CREEK-MD</u> | |
| 24. REC'D BY REGISTRAR <u>Feb 24-1955</u> | | REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer E Bullock</u> | | ADDRESS <u>HAVRE-DE-GRAVE</u> | |

BUREAU V.

1955 28 3

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Chapman, Robert

Die besten Waffeln

1890

1659

01647

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 185-

| | | | | | |
|--|--------------------------------|--|--|--|---|
| 1. PLACE OF DEATH: | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | |
| COUNTY <i>Harford</i> | MARYLAND | | STATE <i>Md</i> | COUNTY <i>Harford</i> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Harveyside</i> | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits write RURAL and give nearest town) TOWN <i>Perryman</i> | X | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Harford Memorial</i> | | | STREET ADDRESS (If rural, give location) <i>1</i> | | |
| 3. NAME OF DECEASED: (Type or Print) <i>Steven A Hughes</i> | | | 4. DATE OF DEATH (Month) (Day) (Year) <i>February 20 1953</i> | | |
| 5. SEX: <i>male</i> | 6. COLOR OR RACE: <i>white</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>widowed</i> | 8. DATE OF BIRTH: <i>Oct. 27 1870</i> | 9. AGE last birthday: <i>84</i> yrs. | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life even if retired) <i>Retired Crop Farmer</i> | | | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): <i>Harford Co., Md.</i> | |
| 13. FATHER'S NAME: <i>Evan Hughes</i> | | | 14. MOTHER'S MAIDEN NAME: <i>Sarah Garrell</i> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service) | | | 16. SOCIAL SECURITY No.: <i>213-28-0281</i> | | |
| | | | 17. INFORMANT & ADDRESS: <i>Mrs. Mahel Russell</i> | | |

| | | | | | |
|---|--|---|---|--|--|
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | 18. MEDICAL CERTIFICATION | | |
| 816 X Immediate cause | | | (a) <i>Fracture skull</i> | | |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last | | | (b) DUE TO | | |
| | | | (c) DUE TO | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | <i>Fracture R femur</i> <i>Fracture ribs, multiple</i> | | |
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDING OF OPERATION: | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <i>Home</i> | | 21c. (City or town) (County) (State) <i>Aberdeen Harford Md</i> | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>2/20/55 8:15</i> M. | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? <i>Auto accident, auto - auto type</i> | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | |
| SIGNATURE <i>Ronald C Palmer</i> | | M. D. <i>2/20/55</i> | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i> | | DATE THEREOF: <i>Feb. 23 1955</i> | | NAME OF CEMETERY OR CREMATORY: <i>Rock Run Cem</i> | |
| LOCATION (City, town, or county) (State): <i>Harford Co., Md.</i> | | 24. FUNERAL DIRECTOR: <i>H. S. Bailey</i> | | ADDRESS: <i>Baltimore, Md.</i> | |
| DATE REC'D BY LOCAL REG. <i>Feb 23 1955</i> | | REGISTRAR'S SIGNATURE: <i>G. L. Lewis M.D.</i> | | | |

MARGIN RESERVED FOR BINDING

VS. A15A-5-53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 25 1965

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial/transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1660

01648

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

| | | | | | | | |
|---|-------------------------------|--|-------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH COUNTY <i>Harford</i> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <i>Harrell Chase</i> TOWN <i>Harrell Chase</i> HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>137 Deaver</i> | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Harford</i> CITY (If outside corporate limits, write RURAL and give nearest town) <i>Harrell Chase</i> TOWN <i>Harrell Chase</i> STREET ADDRESS (If rural give location) <i>137 Deaver</i> | | | |
| 3. NAME OF DECEASED (Type or Print) <i>Oliver J. Jones</i> | | | | 4. DATE OF DEATH (Month) <i>2</i> (Day) <i>26</i> (Year) <i>1955</i> | | | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>White</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i> | 8. DATE OF BIRTH <i>Oct 31-1881</i> | 9. AGE last birthday <i>73</i> yrs. | IF UNDER 1 YEAR Months <i>19</i> Days <i>19</i> Hours <i>19</i> Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Engineer</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Laundry</i> | | 11. BIRTHPLACE (State or foreign country) <i>Sailorville Md</i> | | 12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>John Jones</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Margaret ?</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>215-09-5157</i> | | 17. INFORMANT & ADDRESS <i>Francis E. Jones 137 Deaver St.</i> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE (A) <i>Cardiac Decompensation</i> | | | | | | <i>Sup</i> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <i>Coronary Insufficiency</i> | | | | | | <i>3 weeks</i> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <i>Arterio Sclerotic Heart Disease</i> | | | | | | <i>1 year</i> | |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 2D. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <i>2/15/55</i> , to <i>2/26/55</i> , that I last saw the deceased alive on <i>2/20/55</i> , and that death occurred at <i>5:30 A.M.</i> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>Frank W. Macdonald M.D.</i> | | ADDRESS (Street, city, town, state) <i>Harrell Chase Md</i> | | DATE SIGNED <i>2/28/55</i> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | DATE THEREOF <i>2/28/55</i> | NAME OF CEMETERY OR CREMATORY <i>Angel Hill</i> | | LOCATION (City, town, or county) (State) <i>Harrell Chase, Md.</i> | | | |
| 24. REC'D BY REGISTRAR <i>G. L. Lewis M.D.</i> | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE <i>James E. Jones</i> | | ADDRESS <i>Harrell Chase, Md.</i> | |
| DATE <i>Feb-28-1955</i> | | | | | | | |

THE UNIVERSITY OF MICHIGAN LIBRARY

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1.55 10M

1661

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01649

Req. Dist. No. 185-

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY <u>Harford</u> | MARYLAND | STATE <u>MD</u> | COUNTY <u>Harford</u> |
| CITY OR TOWN <u>Harre-de-Grace</u> | LENGTH OF STAY (in this place) <u>36 hrs.</u> | CITY OR TOWN <u>Bel Air, Md</u> | <u>32</u> |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u> | | STREET ADDRESS (If rural give location) | <u>1</u> |
| 3. NAME OF DECEASED (First) (Middle) (Last) <u>Baby Girl</u> <u>Linger</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>February 18</u> <u>1955</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>2-17-55</u> |
| 9. AGE last birthday <u>36 hrs</u> | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS Hours Min. |
| 10a. USUAL OCCUPATION (Give nature of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | 11. BIRTHPLACE (State or foreign country) <u>Harre-de-Grace Hospital, Md.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>US</u> | | 13. FATHER'S NAME <u>Donald Linger</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Josephine Valli</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>✓</u> | |
| 16. SOCIAL SECURITY NO. <u>✓</u> | | 17. INFORMANT & ADDRESS <u>Donald Linger, 26 Linden St. Baltimore</u> | |
| 18. MEDICAL CERTIFICATION | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| 7543 IMMEDIATE CAUSE (A) <u>intra-aortal Septal Defect (Congenital)</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21a. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21b. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | 21c. HOW DID INJURY OCCUR? | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 22. I hereby certify that I attended the deceased from <u>2/17/55</u> , to <u>2/18/55</u> , that I last saw the deceased alive on <u>2/18/55</u> , and that death occurred at <u>6:30</u> P.M., from the causes and on the date stated above. | | | |
| SIGNATURE <u>Frederick J. [Signature]</u> | | ADDRESS (Street, city, town, state) <u>1711 [Address]</u> | |
| DATE SIGNED <u>2/19/55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>Feb 19/55</u> | |
| NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u> | | LOCATION (City, town, or county) (State) <u>Bel Air, Md</u> | |
| 24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u> | |
| ADDRESS <u>Bel Air, Md</u> | | | |

CERTIFICATE OF DEATH

REG. DIST. NO.

USUAL RESIDENCE (HOMES OF DECEASED)

COUNTY

DECEASED

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

IMMEDIATE CAUSE

IMMEDIATE CAUSE

IMMEDIATE CAUSE

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IMMEDIATE CAUSE

IMMEDIATE CAUSE

BUREAU V. S.

FEB 25 1955

RECEIVED

EXHIBIT

STATE OF MARYLAND
DEPARTMENT OF HEALTH
BALTIMORE
FEB 25 1955
RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1674

CERTIFICATE OF DEATH

Reg. Dist. No. 182

01650

| | | | | | | | |
|--|--------------------------------|--|--|--|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Harford</u> MARYLAND | | | | STATE <u>Md</u> COUNTY <u>Harford</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural--Bel Air</u> | | | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Joppa, Maryland</u> | | | |
| TOWN <u>Rural--Bel Air</u> LENGTH OF STAY (in this place) <u>17 days</u> | | | | TOWN <u>Joppa, Maryland</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Almshouse--Harford Co.</u> | | | | STREET ADDRESS (If rural give location) <u>/</u> | | | |
| 3. NAME OF DECEASED: (Type or Print) | | (First) <u>ELBERT</u> (Middle) <u>A</u> (Last) <u>LOWERY</u> | | 4. DATE (Month) (Day) (Year) OF DEATH: <u>February 14</u> <u>1955</u> | | | |
| 5. SEX: <u>Male</u> | 6. COLOR OR RACE: <u>Negro</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Wid.</u> | 8. DATE OF BIRTH: <u>20th March 1888</u> | 9. AGE last birthday <u>66</u> yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>Farm</u> | 11. BIRTHPLACE (State or foreign country): <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME: <u>Lewis Lowery</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Ellen Reynolds</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMOED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS: <u>Forge Road</u> <u>Mrs. Cora L. Gwynn Fullerton, Md.</u> | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) <u>CEREBRAL THROMBOSIS</u> | | | | | | 6 days | |
| DUE TO | | | | | | | |
| ANTECEDENT CAUSE (B) <u>HYPERTENSIVE CARDIO-VASCULAR DISEASE</u> | | | | | | ? | |
| DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from Jan. 20, 1955 to Feb. 14, 1955, that I last saw the deceased alive on Feb. 12, 1955, and that death occurred at 8:30 P.M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Willard P. Heddon</u> | | ADDRESS <u>M.D. Forest Hill, Md.</u> | | DATE SIGNED <u>2-14-55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>2/17/55</u> | | NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Methodist</u> | | LOCATION (City, town, or county) (State) <u>Mountains, Maryland</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>2-16-55</u> | | REGISTRAR'S SIGNATURE <u>Priscilla Fournod</u> | | 24. FUNERAL DIRECTOR <u>Otelia J. Bullock</u> | | ADDRESS <u>Harde de Grace, Md.</u> | |

RECEIVED
FEB 21 1955
BUREAU V. S.

MARYLAND 1675

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 182

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH COUNTY <u>Harford</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) X <u>Belt Air Rural</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Belt - Air Rural</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kalter Nursing Home</u> | | STREET ADDRESS <u>Kalter Nursing Home</u> | |
| 3. NAME OF DECEASED (Type or Print) <u>Ruth Ann McDoo N</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>February 22 1955</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u> | 8. DATE OF BIRTH <u>Nov. 11, 1872</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife at home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Harford Co., Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>John Lamb</u> | | 14. MOTHER'S MAIDEN NAME <u>Genett Harper</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give year or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>MD</u> | |
| 17. INFORMANT AND ADDRESS <u>John Lamb</u> | | 18. MEDICAL CERTIFICATION <u>Port. H. Posit.</u> | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (a) Immediate cause <u>422.1</u> | | | |
| (b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | | | |
| (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPTSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 21. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | PLACE (Home, farm, factory, street, or office bldg., etc.) | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> | |
| HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>1/15</u> , 19 <u>55</u> , to <u>2/22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Feb 21</u> , 19 <u>55</u> , and that death occurred at <u>9:30 A</u> m., from the causes and on the date stated above. | | | |
| SIGNATURE <u>Gerald C Palmer</u> | | ADDRESS <u>MD Belt Air rd.</u> | |
| DATE SIGNED <u>2/22/55</u> | | | |
| 23. BURIAL, CREMATION, DATE REMOVAL (Specify) <u>Buried Feb. 24, 1955</u> | | NAME OF CEMETERY OR CREMATORY <u>Hubler M. Cn.</u> | |
| LOCATION (City, town, or county) (State) <u>Harford Co., Md.</u> | | | |
| DATE PROC'D BY LOCAL REG. <u>Feb. 23 1955</u> | | REGISTRAR'S SIGNATURE <u>Muriella Lowndes</u> | |
| 24. FUNERAL DIRECTOR <u>H. S. Bailey</u> | | ADDRESS <u>Darlington Md.</u> | |

MARGIN RESERVED FOR BINDING

RECEIVED

MAR 7 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01652

1676

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Harford</u> | | MARYLAND | | STATE <u>md</u> | | COUNTY <u>Harford</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | | X | |
| X TOWN <u>Bel Air Rural</u> | | <u>6 days</u> | | TOWN <u>Kalma</u> | | X | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Convalescent Home</u> | | | | STREET ADDRESS (If rural give location) <u>Bel Air R.D.</u> | | | |
| 3. NAME OF DECEASED: (Type or Print) <u>G. SHERMAN</u> (First) (Middle) (Last) <u>MINK</u> | | | | 4. DATE OF DEATH: <u>Feb 2</u> (Month) (Day) (Year) <u>1955</u> | | | |
| 5. SEX: <u>m.</u> | | 6. COLOR OR RACE: <u>w</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u> | | 8. DATE OF BIRTH: <u>1864 91</u> yrs. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: | | 9. AGE last birthday | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 11. BIRTHPLACE (State or foreign country): <u>Ash Co. N.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | 13. FATHER'S NAME: <u>not known</u> | | 14. MOTHER'S MAIDEN NAME: <u>Mehaley Mink</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>—</u> | | 17. INFORMANT & ADDRESS: <u>Deane H. Mink, Rocke, Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) <u>420.1 CORONARY OCCLUSION</u> | | | | | | 1 hr. | |
| ANTECEDENT CAUSE (S) DUE TO (B) <u>Chn. CARDIO-VASCULAR DISEASE</u> | | | | | | ? | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Chn. ARTHRITIS</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) | | INJURY OCCUR? | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>May 5</u> , 19 <u>48</u> , to <u>2/2/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>1/26/55</u> , 19 <u>55</u> , and that death occurred at <u>10⁰⁰</u> M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Willard P. Hudson</u> | | | | DATE SIGNED <u>2/3/55</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | | | DATE THEREOF <u>Feb 5, 1955</u> | | | |
| NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u> | | | | LOCATION (City, town, or county) <u>Bel Air, Harford Co. Md.</u> | | | |
| DATE REC'D BY LOCAL REGISTRAR <u>2-4-55</u> | | REGISTRAR'S SIGNATURE <u>Priscilla Lowood</u> | | 24. FUNERAL DIRECTOR <u>Martin G. Kurtz</u> | | ADDRESS <u>Jarrettsville, Md.</u> | |

FEB 9 1955

BUREAU V. S.

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1662

01653

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>HARFORD -</u> | | STATE <u>MARYLAND</u> | | COUNTY <u>HARFORD</u> | | STATE <u>MARYLAND</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | |
| TOWN <u>HAVRE DE GRACE, Md -</u> | | <u>12 HRS.</u> | | TOWN <u>HAVRE DE GRACE, Md</u> | | <u>24</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD Memorial Hospital</u> | | | | STREET ADDRESS (If rural give location) <u>666 Green St</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>George</u> (Middle) <u>Nelson</u> (Last) <u>Mitchell</u> | | | | (Month) <u>February</u> (Day) <u>18</u> (Year) <u>1955</u> | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | | 8. DATE OF BIRTH | |
| <u>M</u> | | <u>W</u> | | <u>(SINGLE)</u> | | <u>JULY 21, 1889</u> | |
| 9. AGE last birthday | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <u>65</u> yrs. | | <u>SCHAUFER</u> | | <u>HARFORD Co. MD</u> | | <u>U.S.A.</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>Robert O Mitchell</u> | | | | <u>MARY AMANDA WALKER</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| <u>(No)</u> | | <u>217-05-7905</u> | | <u>G. NELSON MITCHELL</u> <u>HAVRE DE GRACE, MD</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) <u>ACUTE CORONARY OCCLUSION</u> | | | | | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) _____ | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____ | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. MAJOR FINDINGS OF OPERATION | | | |
| _____ | | | | _____ | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| <input type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| _____ | | _____ | | _____ | | | |
| 22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, _____, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>R. B. Permut</u> | | | | DATE SIGNED <u>Feb 21, 1955</u> | | | |
| ADDRESS (Street, city, town, state) | | | | ADDRESS (Street, city, town, state) | | | |
| <u>602 S. Union</u> | | | | <u>HAVRE DE GRACE, MD.</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>BURIAL</u> | | <u>FEB 21, 1955</u> | | <u>ANGEL HILL CEM.</u> | | <u>HAVRE DE GRACE, MD.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>Feb 21 - 1955</u> | | <u>A. L. Lewis</u> | | <u>R. Madison Mitchell</u> | | <u>HAVRE DE GRACE, MD.</u> | |

1. The first step in the process of identifying a potential threat to national security is to determine the nature and scope of the threat. This involves a thorough analysis of the threat's source, its objectives, and its potential impact on the nation's security.

2. Once the threat has been identified, the next step is to assess the threat's severity. This involves evaluating the threat's potential to cause harm to the nation's security, its likelihood of occurring, and the potential for escalation.

3. The third step in the process is to develop a response plan. This involves identifying the resources and personnel needed to respond to the threat, and developing a strategy for dealing with the threat.

4. The final step in the process is to implement the response plan. This involves coordinating the efforts of the relevant agencies and personnel, and taking the necessary actions to deal with the threat.

BUREAU V. S.

FEB 23 1975

RECEIVED

1677

CERTIFICATE OF DEATH

Reg. Dist. No. 182

| | | | | | | | |
|---|--------------------------------|---|---------------------------------------|---|--|--|------------------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>HARFORD</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>HARFORD</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Pylesville Md.</u> | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pylesville Md.</u> | | OR TOWN <u>Pylesville Md.</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) <u>Pylesville Md.</u> | | | |
| 3. NAME OF DECEASED: (Type or Print) <u>Edward</u> (First) <u>O.</u> (Middle) <u>Mitchel</u> (Last) | | | | 4. DATE OF DEATH: <u>Feb. 15</u> (Month) <u>1955</u> (Year) | | | |
| 5. SEX: <u>Male</u> | 6. COLOR OR RACE: <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH: <u>Oct. 12-1897</u> | 9. AGE last birthday: <u>57</u> yrs. | IF UNDER 1 YEAR: Months <u>4</u> Days <u>5</u> Hours <u>5</u> Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Farmer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY: <u>Farmer</u> | | 11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | 13. FATHER'S NAME: <u>Joseph Mitchel</u> | | | |
| 14. MOTHER'S MAIDEN NAME: <u>Emmal Housigle</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | | |
| 16. SOCIAL SECURITY No.: <u>1-10-100000000</u> | | | | 17. INFORMANT & ADDRESS: <u>Albert Mitchel Pylesville Md.</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 420.1 Immediate cause (a) <u>Coronary Thrombosis</u> | | | | Interval Between Onset and Death <u>10 days</u> | | | |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Arteriosclerosis. Chronic Myocarditis</u> | | | | (c) <u>?</u> | | | |
| 11. OTHER SIGNIFICANT CONDITIONS | | | | | | | |
| Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | | |
| 19a. DATE OF OPERATION: | | | | 19b. MAJOR FINDINGS OF OPERATION | | | |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | | | | | |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | | (CITY OR TOWN) | | (COUNTY) (STATE) | |
| TIME (Month) (Day) (Year) (Hour) OF INJURY | | INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Dec 10, 1954</u> , to <u>Dec 14, 1955</u> , that I last saw the deceased alive on <u>Dec 14, 1955</u> , and that death occurred at <u>8:30 A.M.</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Edward H. Nelson</u> (Degree or title) <u>M.D.</u> | | | | DATE SIGNED <u>Feb 17, 1955</u> | | | |
| ADDRESS <u>Four Grove, Pa.</u> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | DATE THEREOF <u>Feb. 19-1955</u> | | NAME OF CEMETERY OR CREMATORY <u>Windsor Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Windsor Co. P.</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>2-18-55</u> | | REGISTRAR'S SIGNATURE <u>Priscilla Lowwood</u> | | 24. GENERAL DIRECTOR <u>Benjamin W. Graham</u> | | ADDRESS <u>Stewartstown Pa.</u> | |

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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INSTRUCTIONS

1 **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1678

01656

CERTIFICATE OF DEATH

Reg. Dist. No. 180

| | | | | | | | |
|---|-------------------------------|--|---|--|-----------------|--|------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Harford | | MARYLAND | | STATE Maryland | | COUNTY Harford | |
| CITY OR TOWN Abingdon | | LENGTH OF STAY (in this place) lifetime | | CITY OR TOWN Abingdon | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) Marie (Middle) M. (Last) Moulsdale | | | | (Month) FEBRUARY (Day) 23 (Year) 1955 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH Feb. July, 21, 1900 | 9. AGE last birthday 54 yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Frederick Morlok | | | | 14. MOTHER'S MAIDEN NAME Rosie De Martin | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT & ADDRESS Andrew G. Moulsdale, Abingdon, Md., | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) GENERALIZED CARCINOMATOSIS | | | | | | OVER 1 YR | |
| ANTECEDENT CAUSE(S) DUE TO ADENOCARCINOMA RECTO SIGMOID | | | | | | " " | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION Jan. 29, 1955 | | 19b. MAJOR FINDINGS OF OPERATION ADENOCARCINOMA RECTO SIGMOID WITH METASTASES | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from JULY , 19 54 , to 23 Feb. , 19 55 , that I last saw the deceased alive on 22 Feb. , 19 55 , and that death occurred at 11:30P. M, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE Philip W. Newman | | M.D. 307 Hickory, Belair, Md. | | DATE SIGNED 24 Feb 1955 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF Feb. 26, 1955 | | NAME OF CEMETERY OR CREMATORY St. Paul's Lutheran | | LOCATION (City, town, or county) (State) Stepney, Harford, Md. | |
| 24. REC'D BY REGISTRAR Feb. 26, 1955 | | REGISTRAR'S SIGNATURE Norma G. Moore | | 25. FUNERAL DIRECTOR'S SIGNATURE Howard K. McComas & Son, Abingdon, Md. | | ADDRESS Howard K. McComas & Son | |

CERTIFICATE OF DEATH

Reg. No. 100

DATE WHEN DEATH OCCURRED

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DATE OF BIRTH

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INSTRUCTIONS

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1663 MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

01655

Reg. Dist. No. 185

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>HARFORD</u> | | STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) | | CITY (If outside corporate limits, write RURAL and give nearest town) | |
| OR TOWN <u>HAUCE DE GRACE</u> | | LENGTH OF STAY (in this place) <u>13 HRS.</u> | | TOWN <u>Whiteford</u> | | X | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD MEMORIAL HOSP.</u> | | | | STREET ADDRESS (If rural give location) <u>1</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>HENRY JAMES NORRIS</u> | | | | 4. DATE OF DEATH <u>FEBRUARY 13 1955</u> | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>White</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u> | | 8. DATE OF BIRTH <u>2, 8, 1868</u> | |
| 9. AGE last birthday <u>87</u> yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POSTMASTER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Civil Service</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>MATTHEW NORRIS</u> | | | | 14. MOTHER'S MAIDEN NAME <u>SUSANNA Giffing</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT'S ADDRESS <u>2 Ghytelle</u> | | | |
| 1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 420.1 IMMEDIATE CAUSE (A) <u>Coronary occlusion with myocardial infarction</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovascular disease</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>2600</u> | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>① Bronchopneumonia ② Diabetes Mellitus</u> | | | | | | | |
| 19a. DATE OF OPERATION <u>none</u> | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>White</u> <input type="checkbox"/> <u>Not White</u> <input type="checkbox"/> | | 21e. INJURY OCCURRED <u>at work</u> <input type="checkbox"/> <u>et work</u> <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>Feb 12th, 1955</u> , to <u>Feb 13th, 1955</u> , that I last saw the deceased alive on <u>Feb 12th, 1955</u> , and that death occurred at <u>1:13 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Edward L. Lewis</u> | | M.D. <u>420 N. Union Ave. Harre del Grace, Md. 2/13/55</u> | | ADDRESS (Street, city, town, state) | | DATE SIGNED | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | DATE THEREOF <u>FEB. 16, 1955</u> | | NAME OF CEMETERY OR CREMATORY <u>SLATE RIDGE</u> | | LOCATION (City, town, or county) (State) <u>DEI TA, PA.</u> | |
| 24. REC'D BY REGISTRAR <u>Feb. 14 - 55</u> | | REGISTRAR'S SIGNATURE <u>G. L. Lewis</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins</u> | | ADDRESS <u>Dei Ta, Pa.</u> | |

CERTIFICATE OF DEATH

1955

UNITED STATES DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

STATE OF MARYLAND

DATE OF DEATH

TIME

PLACE

CAUSE OF DEATH

AGE

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RACE

EDUCATION

OCCUPATION

RELIGION

ETHNICITY

DIAGNOSIS

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FEB 15 1955

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UNRECORDED

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS THE PROPERTY OF THE STATE OF MARYLAND. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO THE PUBLIC UPON REQUEST AND PAYMENT OF THE FEE THEREFOR. IT IS TO BE DESTROYED AFTER THE EXPIRATION OF THE FIFTY YEAR PERIOD.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 01657
 Reg. Dist.

| | | | | | | | |
|---|-------------------|--|-------------------|--|----------------------------------|--|-------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY Harford | | MARYLAND | | STATE Md. | | COUNTY Harford | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits write RURAL and give nearest town) | | | |
| TOWN Bel Air | | | | TOWN Bel Air | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 308 N. Main Street | | | | STREET ADDRESS (If rural, give location) 308 N. Main Street | | | |
| 3. NAME OF DECEASED: | | | | 4. DATE OF DEATH | | | |
| (First) NORMAN | | (Middle) MUNDER PRATHER | | (Last) | | (Month) (Day) (Year) | |
| (Type or Print) | | | | | | Feb. 16 19 55 | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE MARRIED, WIDOWED , DIVORCED | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR IF UNDER 24 HRS. | | |
| Male | White | (Specify): | 9/30/1905 | 49 yrs. | Months | Days | Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): | | | | 10b. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): | |
| W. Md. Dairy | | | | Baltimore Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13. FATHER'S NAME: | | | | 14. MOTHER'S MAIDEN NAME: | | | |
| William Francis Prather | | | | Isabella Clendenin | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY No.: | | 17. INFORMANT & ADDRESS: | |
| no | | | | 212-03-2977 | | Mrs. Ruth Russell Prather Belair, Md. | |

| | | | | | | | |
|---|--|--|--|--------------------------------------|--|--|--|
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | | | | | |
| 421.1 Immediate cause (a)..... Calcific aortic stenosis..... | | | | | | | |
| DUE TO | | | | | | | |
| Antecedent cause(s) (b)..... Myocardial hypertrophy..... | | | | | | | |
| Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) | | | | | | | |
| DUE TO | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDING OF OPERATION: | | | | 20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | | 21c. (City or town) (County) (State) | | | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M. | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| SIGNATURE | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| William J. Smith | | Feb 19-1955 | | Belair Memorial Gardens, Belair Md | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): | | DATE REC'D BY LOCAL REG. | | REGISTRAR'S SIGNATURE | | 24. GENERAL DIRECTOR ADDRESS | |
| Burial | | 2/12/55 | | A.W. Hedrick | | Baltimore Md | |

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1679

CERTIFICATE OF DEATH

01658

Reg. Dist. No. 181

| | | | | | | | |
|--|--------------------------------------|---|--|---|--|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Harford</u> | | MARYLAND | | STATE <u>Maryland NY</u> COUNTY <u>Harford</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Aberdeen</u> | | <u>31 days</u> | | TOWN <u>(Aberdeen) Jamestown</u> | | <u>69X-3</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u> | | | | STREET ADDRESS (If rural give location) | | | |
| <u>Aberdeen Proving Ground, Md.</u> | | | | <u>302 Old Post Road</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>VERNA</u> (First) <u>DOTT</u> (Middle) <u>SHAFFER</u> (Last) | | | | 4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>19</u> (Year) <u>1955</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> | 8. DATE OF BIRTH <u>Jan. 20, 1955</u> | 9. AGE last birthday yrs. <u>30</u> | IF UNDER 1 YEAR Months <u>30</u> Days <u>30</u> | IF UNDER 24 HRS. Hours <u>30</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Robert J. Shaffer</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Georgina D. Erickson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>---</u> | | 17. INFORMANT & ADDRESS <u>Robert J Shaffer</u> <u>302 Old Post Rd, Aberdeen, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| IMMEDIATE CAUSE (A) <u>Cerebral Anoxia with resultant inability to swallow</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>31 days</u> | |
| ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | | | | |
| (B) <u>Atelectasis</u> | | | | | | | |
| (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>Feb 19</u> , 19 <u>55</u> , to <u>Feb 19</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Feb 19</u> , 19 <u>55</u> , and that death occurred at <u>1:10 PM</u> , from the causes and on the date stated above. <u>19 Feb 55</u> | | | | | | | |
| SIGNATURE <u>Robert D Hume Jr.</u> | | | | ADDRESS (Street, city, town, state) <u>Aberdeen Proving Ground, Md.</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u> | | | | DATE THEREOF <u>2/22/55</u> | | | |
| 24. REC'D BY REGISTRAR <u>Pellie G. Perry</u> | | | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Hanning</u> | | | |
| DATE <u>2/22/55</u> | | | | ADDRESS <u>Aberdeen Md.</u> | | | |

2015232354

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01659

1680

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <i>Harford</i> | | MARYLAND | | STATE <i>Maryland</i> | | COUNTY <i>Harford</i> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | | X | |
| X TOWN <i>Fallston Rural</i> | | <i>3 mo.</i> | | TOWN <i>Fallston</i> | | X | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 00 | | | | <i>Rural</i> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | | | 4. DATE (Month) (Day) (Year) | | | |
| <i>William Franklin SPARKS</i> | | | | <i>Feb- 6- 1955</i> | | | |
| 5. SEX: <i>M</i> | | 6. COLOR OR RACE: <i>W</i> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i> | | 8. DATE OF BIRTH: <i>Oct. 17, 1950</i> | |
| | | | | 9. AGE last birthday: <i>4</i> yrs. | | IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | | 10B. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): | | 12. CITIZEN OF WHAT COUNTRY? | |
| | | | | <i>York Pa</i> | | <i>US</i> | |
| 13. FATHER'S NAME: | | | | 14. MOTHER'S MAIDEN NAME: | | | |
| <i>Jesse Sparks</i> | | | | <i>Mary Duncan</i> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS: | | | |
| | | | | <i>Jesse Sparks, Fallston Md</i> | | | |
| 18. MEDICAL CERTIFICATION | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) <i>Septicemia</i> | | | | | | | <i>?</i> |
| DUE TO | | | | | | | |
| ANTECEDENT CAUSE (S) (B) <i>ac. Staphylococcal Tonsillitis</i> | | | | | | | <i>?</i> |
| DUE TO | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) | | INJURY OCCUR? | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| M. | | | | | | | |
| 22. I hereby certify that I attended the deceased from <i>Feb 5, 1955</i> , to <i>Feb 5, 1955</i> that I last saw the deceased alive on <i>Feb 5, 1955</i> , and that death occurred at <i>12:15 P M</i> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>Wesley P. Hudson</i> | | | | ADDRESS <i>Forest Hill</i> | | DATE SIGNED <i>2/7/55</i> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <i>Burial</i> | | <i>Feb 8 1955</i> | | <i>Friendship Methodist</i> | | <i>Fallston Md</i> | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | | ADDRESS | |
| <i>2/7/55</i> | | <i>W. H. Archer</i> | | <i>W. H. Archer</i> | | <i>Benson Md</i> | |

RECEIVED
FEB 9 1955
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1665
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 1665 Film 11/29/44-5-55 am

01660
Reg. Dist. No. 185

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>HARFORD</u> | | MARYLAND | | STATE <u>MD</u> | | COUNTY <u>HARFORD</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>HAVERDE GRACE</u> | | | | CITY (If outside corporate limits write RURAL and give nearest town) <u>HAVERDE GRACE</u> | | | |
| TOWN <u>BELAIR</u> | | LENGTH OF STAY (In this place) <u>4 YRS.</u> | | TOWN <u>BELAIR - HARFORD CTY. MD</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>131 WEBER STREET</u> | | | | STREET ADDRESS (If rural, give location) <u>131 WEBER STREET</u> | | | |
| 3. NAME OF DECEASED: | | | | 4. DATE OF DEATH: | | | |
| (First) <u>RONALD</u> | | (Middle) <u>STILLMAN</u> | | (Month) <u>2</u> | | (Day) <u>19</u> | |
| (Type or Print) | | | | (Year) <u>1955</u> | | | |
| 5. SEX: <u>MALE</u> | | 6. COLOR OR RACE: <u>WHITE</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>SINGLE</u> | | 8. DATE OF BIRTH: <u>JULY 1, 1950</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>NONE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY: <u>NONE</u> | | 9. AGE last birthday: <u>4</u> yrs. | | 11. BIRTHPLACE (State or foreign country): <u>HAVERDE GRACE</u> | |
| 13. FATHER'S NAME: <u>EUGENE I STILLMAN</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>RUBY G SAYERS</u> | | | |
| 16. SOCIAL SECURITY No.: <u>NONE</u> | | | | 17. INFORMANT & ADDRESS: <u>EUGENE I STILLMAN, 131 WEBER ST, HAVERDE GRACE, MD</u> | | | |

| | | |
|---|--|--|
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | INTERVAL BETWEEN ONSET AND DEATH |
| <p>576X Immediate cause (a) <u>Generalized peritonitis</u></p> <p>Antecedent cause(s) (b) <u>DUE TO</u></p> <p>Diseases or conditions, if any, giving rise to the above cause <u>DUE TO</u></p> <p>stating underlying cause last (c)</p> | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | |
| 19a. DATE OF OPERATION: | | 20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| 19b. MAJOR FINDING OF OPERATION: | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21c. (City or town) (County) (State) |
| 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | | |
| 21d. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY | | 21f. HOW DID INJURY OCCUR? |
| 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> . | | |
| SIGNATURE <u>Paul F. Siler</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>2-19-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/> |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u> | | 24. FUNERAL DIRECTOR ADDRESS |
| DATE THEREOF <u>2/20/55</u> | | LOCATION (City, town, or county) (State) <u>HAVERDE GRACE HARFORD, MD</u> |
| NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL</u> | | |
| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Feb. 20-1955 G. L. Lewis M.D.</u> | | 24. FUNERAL DIRECTOR ADDRESS <u>G. L. Lewis M.D. Pennington + Son, Haverde Grace, Md</u> |

Items 1665 Film 11/29/44-5-55 am

RECEIVED

FEB 28 1955

BUREAU V. S.

1681

01662
Reg. Dist. No. 180MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY Harford | MARYLAND | STATE Maryland | COUNTY Harford |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Abingdon | LENGTH OF STAY (in this place) 4 yrs., | CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Abingdon | X |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural, give location) | |
| 3. NAME OF DECEASED: (First) James (Middle) F. (Last) Van Valkenburgh, Jr., | | 4. DATE OF DEATH (Month) February (Day) 18 (Year) 1955 | |
| 5. SEX: male | 6. COLOR OR RACE: white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married | 8. DATE OF BIRTH: Feb. 8, 1920 |
| 9. AGE last birthday: 35 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Engineer | | 10b. KIND OF BUSINESS OR INDUSTRY: Aircraft | |
| 11. BIRTHPLACE (State or foreign country): North Carolina | | 12. CITIZEN OF WHAT COUNTRY: U.S.A. | |
| 13. FATHER'S NAME: James F. Van Valkenburgh | | 14. MOTHER'S MAIDEN NAME: Annie Boling | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) yes (If Yes, give war or dates of service) W.W. II | | 16. SOCIAL SECURITY No.: 240-16-5753 | |
| 17. INFORMANT & ADDRESS: Regina M. Van Valkenburgh, Abingdon, Md., | | | |
| 18. MEDICAL CERTIFICATION | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | | INTERVAL BETWEEN ONSET AND DEATH |
| 420.1 Immediate cause (a) Coronary occlusion DUE TO | | | |
| Antecedent cause(s) (b) giving rise to the above cause DUE TO stating underlying cause last (c) | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION: | | 19b. MAJOR FINDING OF OPERATION: | |
| 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY) | 21c. (City or town) (County) (State) | |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| SIGNATURE Donald C. Palmer | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2-18-1955 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM <input type="checkbox"/> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): Removal | DATE THEREOF Feb. 18, 1955 | NAME OF CEMETERY OR CREMATORY Groce Funeral Home | LOCATION (City, town, or county) (State) Asheville North Carolina. |
| DATE REC'D BY LOCAL REG Feb. 21, 1955 | REGISTRAR'S SIGNATURE Norma G. Moore | 24. FUNERAL DIRECTOR ADDRESS Howard K. Mc Comas & Son, Abingdon, Md. | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 23 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

016663
Reg. Dist.

No. 186-

| | | | |
|---|-----------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH: COUNTY <u>Harford</u> MARYLAND | | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Harford</u> | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Lande Chase</u> | | CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Lande Chase</u> 24 | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial</u> | | STREET ADDRESS (If rural, give location) <u>425 N. Union</u> | |
| 3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>Frederick A. Weymouth</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>February 1 1955</u> | |
| 5. SEX: <u>Male</u> | 6. COLOR OR RACE: <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH: <u>7/12/1889</u> |
| 9. AGE last birthday: <u>70</u> yrs. | | 10. IF UNDER 1 YEAR (Month) (Day) (Year) IF UNDER 24 HRS. (Hours) (Min.) | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, if retired): <u>Watchdog</u> | | 10b. KIND OF BUSINESS OR INDUSTRY: <u>Abraham Perry Farm</u> | |
| 11. BIRTHPLACE (State or foreign country): <u>Lowell Mass</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>Samson S.O. Weymouth</u> | | 14. MOTHER'S MAIDEN NAME: <u>Elvira Lumer</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>W.W.I</u> | | 16. SOCIAL SECURITY No.: <u>168-03-3531</u> | |
| 17. INFORMANT & ADDRESS: <u>Melba G. M. Weymouth</u> | | <u>425 N. Union Ave. Lande Chase Md.</u> | |

| | | |
|---|---|--|
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: | | INTERVAL BETWEEN ONSET AND DEATH |
| Immediate cause (a) <u>Communited fracture pelvis</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) | | 1 day |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Rupture urinary bladder</u> | | |
| 19a. DATE OF OPERATION: | 19b. MAJOR FINDING OF OPERATION: | 20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | 21b. PLACE (Home, farm, factory, street, office, bldg., etc.) OF INJURY <u>Home</u> | 21c. (City or town) (County) (State) <u>Harford Harford Md.</u> |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>12/31/55 6 P M.</u> | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 21f. HOW DID INJURY OCCUR? <u>4 into accident, auto-pedestrian type</u> |
| 22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | |
| SIGNATURE <u>Gerald C Palmer</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> <u>2/1/55</u> |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Cremation</u> | DATE THEREOF <u>2/2/55</u> | NAME OF CEMETERY OR CREMATORY <u>Baltimore</u> |
| DATE REC'D BY LOCAL REG. <u>Feb. 2-1955</u> | REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u> | 24. FUNERAL DIRECTOR: <u>Funerary Co</u> |
| | | ADDRESS <u>Harford Harford Md.</u> |

BUREAU V. S.

FEB 7 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1682 CERTIFICATE OF DEATH

01664
Reg. Dist. No. 182

| | | | | | | | |
|--|--|--------------------------------|--|---|--|---|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Harford</u> | | MARYLAND | | STATE <u>Md.</u> | | COUNTY <u>Harford</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| X TOWN <u>Rural Bel Air Road</u> | | <u>8 Mos.</u> | | TOWN <u>Bel - Air Rural</u> | | X | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Walter Nursing Home</u> | | | | STREET ADDRESS (If rural give location) <u>1</u> | | | |
| 3. NAME OF DECEASED: (Type or Print) | | | | 4. DATE (Month) (Day) (Year) OF DEATH: | | | |
| <u>Milton C. Winemiller</u> | | | | <u>Feb. 15 19 55</u> | | | |
| 5. SEX: <u>Male</u> | | 6. COLOR OR RACE: <u>White</u> | | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | | 8. DATE OF BIRTH: <u>Oct. 11, 1876</u> | |
| | | | | | | 9. AGE last birthday <u>78</u> yrs. | |
| | | | | | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): | |
| <u>Store Keeper Country Store</u> | | | | <u>Baltimore Co., Md.</u> | | <u>V. S. A</u> | |
| 13. FATHER'S NAME: <u>Joseph B. Kinemiller</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Lophia Bowman</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give year or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>No</u> | | | |
| 17. INFORMANT & ADDRESS: <u>James G. Kinemiller</u> | | | | | | | |
| 18. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| 422.1 IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u> | | | | | | 20 hrs. | |
| ANTECEDENT CAUSE (S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Chr. Cardio-vascular Disease</u> | | | | | | ? | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | | | 19B. MAJOR FINDINGS OF OPERATION | | | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | | | 21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from July 10, 1954, to Feb. 15, 1955, that I last saw the deceased alive on Feb. 14, 1955, and that death occurred at 3:00 PM, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Willard P. Hudson</u> | | | | ADDRESS <u>M.D. Forest Hill, Md.</u> | | DATE SIGNED <u>2-15-55</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) | | | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | |
| <u>Burial Feb. 18, 1955</u> | | | | <u>Stewartstown Cem.</u> | | <u>York Co., Penna</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>2/18/55</u> | | | | REGISTRAR'S SIGNATURE <u>Percilla Howard</u> | | 24. FUNERAL DIRECTOR <u>H. S. Bailey</u> ADDRESS <u>Portington, Md.</u> | |

BUREAU V. S.

FEB 21 1935

RECEIVED